

AMENDED IN ASSEMBLY JULY 16, 2015

AMENDED IN ASSEMBLY JULY 2, 2015

AMENDED IN SENATE JUNE 1, 2015

AMENDED IN SENATE APRIL 21, 2015

AMENDED IN SENATE MARCH 26, 2015

SENATE BILL

No. 137

Introduced by Senator Hernandez

January 26, 2015

An act to add ~~Sections~~ *Section 1367.27 and 1367.28 to to, and repeal Section 1367.26 of*, the Health and Safety Code, and to add ~~Sections~~ *Section 10133.15 and 10133.16 to the Insurance Code*, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 137, as amended, Hernandez. Health care coverage: provider directories.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. A willful violation of the act is a crime. Existing law requires a health care service plan to provide a list of contracting providers within a requesting enrollee's or prospective enrollee's general geographic area.

Existing law also provides for the regulation of health insurers by the Insurance Commissioner. Existing law requires insurers subject to regulation by the commissioner to provide group policyholders with a current roster of institutional and professional providers under contract to provide services at alternative rates.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. One of the methods by which Medi-Cal services are provided is pursuant to contracts with various types of managed health care plans.

~~Commencing February 1, 2016, this~~ This bill would require health care service plans, and insurers subject to regulation by the commissioner for services at alternative rates, to make an online provider directory available on its Internet Web site, as specified.

~~Commencing, March 15, 2016, the~~ This bill would require the Department of Managed Health Care and the Department of Insurance to jointly develop uniform provider directory standards. ~~Commencing September 15, 2016, or no later than 6 months after the provider directory standards are developed, this~~ The bill would require health care service plans, plans with Medi-Cal managed care contracts, and insurers subject to regulation by the commissioner for services at alternative rates to make an online provider directory available on its Internet Web site and to update the directory weekly, as specified. ~~The bill would require a health care service plan or insurer to reimburse an enrollee or insured for any amount beyond what the enrollee, or insured would have paid for in-network services, if the enrollee or insured reasonably relied on the provider directory, as specified.~~ By placing additional requirements on health care service plans, the violation of which is a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

- 1 SECTION 1. Section 1367.26 of the Health and Safety Code
- 2 is repealed.
- 3 ~~1367.26. (a) A health care service plan shall provide, upon~~
- 4 ~~request, a list of the following contracting providers, within the~~
- 5 ~~enrollee's or prospective enrollee's general geographic area:~~

1 ~~(1) Primary care providers.~~

2 ~~(2) Medical groups.~~

3 ~~(3) Independent practice associations.~~

4 ~~(4) Hospitals.~~

5 ~~(5) All other available contracting physicians and surgeons,~~
6 ~~psychologists, —acupuncturists, —optometrists, —podiatrists,~~
7 ~~chiropractors, licensed clinical social workers, marriage and family~~
8 ~~therapists, professional clinical counselors, and nurse midwives~~
9 ~~to the extent their services may be accessed and are covered~~
10 ~~through the contract with the plan.~~

11 ~~(b) This list shall indicate which providers have notified the~~
12 ~~plan that they have closed practices or are otherwise not accepting~~
13 ~~new patients at that time.~~

14 ~~(c) The list shall indicate that it is subject to change without~~
15 ~~notice and shall provide a telephone number that enrollees can~~
16 ~~contact to obtain information regarding a particular provider. This~~
17 ~~information shall include whether or not that provider has indicated~~
18 ~~that he or she is accepting new patients.~~

19 ~~(d) A health care service plan shall provide this information in~~
20 ~~written form to its enrollees or prospective enrollees upon request.~~
21 ~~A plan may, with the permission of the enrollee, satisfy the~~
22 ~~requirements of this section by directing the enrollee or prospective~~
23 ~~enrollee to the plan's provider listings on its Internet Web site.~~
24 ~~Plans shall ensure that the information provided is updated at least~~
25 ~~quarterly. A plan may satisfy this update requirement by providing~~
26 ~~an insert or addendum to any existing provider listing. This~~
27 ~~requirement shall not mandate a complete republishing of a plan's~~
28 ~~provider directory.~~

29 ~~(e) Each plan shall make information available, upon request,~~
30 ~~concerning a contracting provider's professional degree, board~~
31 ~~certifications, and any recognized subspecialty qualifications a~~
32 ~~specialist may have.~~

33 ~~(f) Nothing in this section shall prohibit a plan from requiring~~
34 ~~its contracting providers, contracting provider groups, or~~
35 ~~contracting specialized health care plans to satisfy these~~
36 ~~requirements. If a plan delegates the responsibility of complying~~
37 ~~with this section to its contracting providers, contracting provider~~
38 ~~groups, or contracting specialized health care plans, the plan shall~~
39 ~~ensure that the requirements of this section are met.~~

~~(g) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number or in writing.~~

~~SECTION 1.~~

~~SEC. 2.~~ Section 1367.27 is added to the Health and Safety Code, to read:

~~1367.27. (a) Commencing February 1, 2016, a health care service plan shall make available an online publish and maintain a provider directory or directories that provide with information on contracting providers that provide deliver health care services to plan the plan's enrollees, including those that accept new patients, pursuant to the requirements of this section and Section 1367.26. patients. A provider directory shall not list or include information on a provider that does not have a current is not currently under contract with the plan.~~

~~(b) A health care service plan shall provide the online directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, enrollees, potential enrollees, the department, and other state or federal agencies can easily identify which providers participate in which networks for which products. A health plan shall use the same consistent naming, numbering, or classification method in provider contracts and communications to ensure that providers can identify the products and networks that they are legally contracted to provide services in. The naming, numbering, or classification shall be consistent across plans in order to permit multiplan directories. the networks and plan products in which a provider participates. By July 31, 2017, or six months after the date provider directory standards are developed under this section, a health care service plan shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).~~

~~(c) The (1) An online provider directory or directories shall be available on the plan's Internet Web site to the public, potential enrollees, enrollees, and providers through a clearly identifiable link or tab and in a manner that is accessible and searchable without any requirement that a member of the public or potential enrollee indicate intent to obtain coverage from the plan. without any restrictions or limitations. The directory or directories shall be~~

1 ~~available to the public without requiring~~ *accessible without any*
 2 *requirement* that an individual seeking the directory information
 3 demonstrate coverage with the plan, *indicate interest in obtaining*
 4 *coverage with the plan*, provide a member identification or policy
 5 number, provide any other identifying information, or create or
 6 access an account.

7 (2) *The online provider directory or directories shall be*
 8 *accessible on the plan's public Internet Web site through a clearly*
 9 *identifiable link or tab and in a manner that is accessible and*
 10 *searchable by enrollees, potential enrollees, the public, and*
 11 *providers. The plan's public Internet Web site shall allow provider*
 12 *searches by name, practice address, distance from specified*
 13 *address, California license number, National Provider Identifier*
 14 *number, admitting privileges to an identified hospital, product,*
 15 *tier, provider language, medical group or independent practice*
 16 *association, hospital name, facility name, or clinic name, as*
 17 *appropriate.*

18 (d) (1) *A health care service plan shall allow enrollees,*
 19 *potential enrollees, and members of the public to request a printed*
 20 *copy of the provider directory or directories by contacting the plan*
 21 *through the plan's toll-free telephone number, electronically, or*
 22 *in writing. A printed copy of the provider directory or directories*
 23 *shall include the information required in subdivisions (h) and (i).*
 24 *The printed copy of the provider directory or directories shall be*
 25 *provided to the enrollee by mail no later than 15 business days*
 26 *following the date of the request and may be limited to the*
 27 *geographic region in which the enrollee resides or works or intends*
 28 *to reside or work.*

29 (2) *A health care service plan shall update its printed provider*
 30 *directory or directories at least quarterly, or more frequently, if*
 31 *required by federal law.*

32 ~~(d)~~
 33 (e) *The plan shall update the online provider directory or*
 34 *directories, at least weekly, with any change to contracting*
 35 *providers, including all of the following: weekly, or more*
 36 *frequently, if required by federal law. Any change in information*
 37 *concerning a listed contracting provider shall be included in the*
 38 *updated version required by this subdivision. A change in*
 39 *information includes, but is not limited to, any of the following:*

1 (1) Whether a contracting provider is no longer accepting new
2 patients for that product, or whether the contracting provider group
3 has identified that a provider of the group is no longer accepting
4 new patients.

5 (2) Whether the provider ~~moved or relocated from~~ *relocated*
6 *out of* the contracted service area of the plan, has retired, or has
7 otherwise ceased to ~~practice, in which case~~ *practice. In all of these*
8 *cases*, the provider shall be deleted from the directory.

9 (3) *Whether the provider is no longer contracted with the plan*
10 *for any reason, in which case the provider shall be deleted from*
11 *the directory.*

12 (4) *Whether the contracted provider is no longer under contract*
13 *for a particular product.*

14 (5) *Whether the provider's practice location or other*
15 *information required under subdivision (h) has changed.*

16 ~~(3)~~

17 (6) Whether the contracting ~~provider group,~~ *medical group,*
18 *independent practice association, or other group of providers,* if
19 any, has informed the plan that the provider is no longer associated
20 with the group and is no longer under contract with the plan, in
21 which case the provider shall be deleted from the directory.

22 (7) *Whether the contracting medical group, independent practice*
23 *association, or other group of providers has informed the plan*
24 *that the provider group is no longer under contract with the plan,*
25 *in which case any provider of the group that does not maintain an*
26 *independent contract with the plan shall be deleted from the*
27 *directory.*

28 ~~(4)~~

29 (8) When the plan identified a change is necessary based on an
30 enrollee complaint that a provider was not accepting new patients,
31 was otherwise not available, or whose contact information was
32 listed incorrectly.

33 ~~(5)~~

34 (9) Any other relevant information that has come to the attention
35 of the plan affecting the content and accuracy of the provider
36 directory.

37 ~~(e)~~

38 (f) The ~~online~~ provider directory or directories shall include
39 both an email address and a telephone number for members of the

1 public and providers to notify the plan if the provider directory
2 information appears to be inaccurate.

3 (f)

4 (g) The ~~online~~ provider directory shall include the following
5 disclosures informing enrollees that they are entitled to both of the
6 following:

7 (1) Language interpreter services, at no cost to the enrollee,
8 including how to obtain interpretation services.

9 (2) Full and equal access to covered services, including enrollees
10 with disabilities as required under the federal Americans with
11 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act
12 of 1973.

13 (h) *A full service health care service plan and a specialized*
14 *mental health plan shall include all of the following information*
15 *in the provider directory or directories:*

16 (1) *The provider's name, practice location or locations, and*
17 *contact information.*

18 (2) *Type of practitioner.*

19 (3) *National Provider Identifier number.*

20 (4) *California license number and type of license.*

21 (5) *The area of specialty, including board certification, if any.*

22 (6) *The provider's office email address, if available.*

23 (7) *The name of all affiliated medical groups currently under*
24 *contract with the plan through which the provider sees enrollees.*

25 (8) *A listing for each of the following providers, facilities, and*
26 *services that are under contract with the plan:*

27 (A) *For physicians and surgeons, the medical group, and*
28 *affiliation or admitting privileges, if any, at hospitals contracted*
29 *with the plan.*

30 (B) *Nurse practitioners, physician assistants, psychologists,*
31 *acupuncturists, optometrists, podiatrists, chiropractors, licensed*
32 *clinical social workers, marriage and family therapists,*
33 *professional clinical counselors, substance abuse counselors,*
34 *qualified autism service providers, nurse midwives, and dentists.*

35 (C) *For federally qualified health centers or primary care*
36 *clinics, the name of the federally qualified health center or clinic.*

37 (D) *For any provider described in subparagraph (A) or (B) who*
38 *is employed by a federally qualified health center or primary care*
39 *clinic, and to the extent their services may be accessed and are*
40 *covered through the contract with the plan, the name of the*

1 provider, and the name of the federally qualified health center or
2 clinic.

3 (E) Facilities, including, but not limited to, general acute care
4 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
5 surgery centers, inpatient hospice, residential care facilities, and
6 inpatient rehabilitation facilities.

7 (F) Pharmacies, clinical laboratories, imaging centers, and
8 other facilities providing contracted health care services.

9 (9) The provider directory may note that authorization or
10 referral may be required to access some providers.

11 (10) Non-English language, if any, spoken by a health care
12 provider or other medical professional as well as non-English
13 language spoken by a qualified medical interpreter, in accordance
14 with Section 1367.04, if any, on the provider's staff.

15 (11) Identification of providers who no longer accept new
16 patients for one or more of the plan's products or for all of the
17 plan's products.

18 (12) Network tier to which the provider is assigned, if the
19 provider is not in the lowest tier, as applicable. Nothing in this
20 section shall be construed to require the use of network tiers other
21 than contract and noncontracting tiers.

22 (13) All other information necessary to conduct a search
23 pursuant to paragraph (2) of subdivision (c).

24 (i) A vision, dental, or other specialized health care service
25 plan, except for a specialized mental health plan, shall include all
26 of the following information for each of the provider directories
27 used by the plan for its networks:

28 (1) The provider's name, practice location or locations, and
29 contact information.

30 (2) Type of practitioner.

31 (3) National Provider Identifier number.

32 (4) California license number and type of license, if applicable.

33 (5) The area of specialty, including board certification, or other
34 accreditation, if any.

35 (6) The provider's office email address, if available.

36 (7) The name of any affiliated medical group, independent
37 practice association, or specialty plan practice group currently
38 under contract with the plan through which the provider sees
39 enrollees.

1 (8) *The names of any allied health care professionals to the*
2 *extent there is a direct contract for those services covered through*
3 *the contract with the plan.*

4 (9) *Non-English language, if any, spoken by a health care*
5 *provider or other medical professional as well as non-English*
6 *language spoken by a qualified medical interpreter, in accordance*
7 *with Section 1367.04, if any, on the provider's staff.*

8 (j) *If a contracting provider, or the representative of a*
9 *contracting provider, informs an enrollee or potential enrollee*
10 *who contacted the provider based on information in the provider*
11 *directory indicating that the provider was accepting new patients*
12 *but the provider is not accepting new patients, then the contract*
13 *between the plan and the provider shall require the provider to*
14 *inform the plan that the provider is not accepting new patients*
15 *and direct the enrollee or potential enrollee to the plan for*
16 *additional assistance in finding a provider and also to the*
17 *department to inform it of the possible inaccuracy in the provider*
18 *directory. If an enrollee or potential enrollee informs a plan of a*
19 *possible inaccuracy in the provider directory or directories, the*
20 *plan shall immediately investigate, and, if necessary, undertake*
21 *corrective action within 30 business days to ensure the accuracy*
22 *of the directory or directories.*

23 (k) (1) *On or before December 31, 2016, the department shall*
24 *develop uniform provider directory standards for purposes of this*
25 *section. Those standards shall not be subject to the Administrative*
26 *Procedure Act (Chapter 3.5 (commencing with Section 11340) of*
27 *Part 1 of Division 3 of Title 2 of the Government Code), until*
28 *January 1, 2021.*

29 (2) *In developing the standards under this subdivision, the*
30 *department shall seek input from interested parties and shall hold*
31 *at least one public meeting. The department shall take into*
32 *consideration any requirements for provider directories established*
33 *by the federal Centers for Medicare and Medicaid Services.*

34 (3) *By July 31, 2017, or six months after the date provider*
35 *directory standards are developed under this subdivision,*
36 *whichever occurs later, a plan shall use the standards developed*
37 *by the department for each product offered by the plan.*

38 (l) *A plan shall establish policies and procedures with regard*
39 *to the regular updating of its provider directory or directories,*
40 *including the weekly, quarterly, and annual updates required*

1 pursuant to this section, or more frequently, if required by federal
2 law or guidance.

3 (m) The policies and procedures established under this
4 subdivision shall be submitted by a plan annually to the department
5 for approval and in a format described by the department pursuant
6 to Section 1367.035.

7 (1) At a minimum, these policies and procedures shall include
8 all of the following:

9 (A) At least annually, the plan shall review and update the entire
10 provider directory or directories for each product offered.

11 (B) At least quarterly, the plan shall notify the contracted
12 provider or provider group, if applicable, of the information the
13 plan has in the directory or directories on the provider or provider
14 group contained in the directory, including a list of networks and
15 plan products that include the contracted provider or provider
16 group. The plan shall include with this notification instructions
17 as to how the provider or provider group can access and update
18 the information using the online interface required by subdivision
19 (o).

20 (2) The plan shall require an affirmative response from the
21 provider or provider group acknowledging that the notification
22 was received. The provider or provider group shall attest that the
23 information in the provider directory is current and accurate or
24 update the information required to be in the directory pursuant to
25 this section, including whether or not the provider or provider
26 group is accepting new patients for each plan product.

27 (3) If the plan does not receive an affirmative response and
28 attestation from the provider that the information is current and
29 accurate or, as an alternative, updates information required to be
30 in the directory pursuant to this section, within 30 business days,
31 the plan shall take investigatory actions as outlined in subdivision
32 (q) to verify whether the provider's information is correct or
33 requires updates. The plan shall complete its investigation and
34 make any required corrections or updates to the provider directory
35 based on its investigation within 30 days from the date the provider
36 was required to provide the affirmative response to the plan. If,
37 at the completion of its investigation, the plan is unable to verify
38 whether the provider's information is correct or requires updates,
39 the provider shall be removed from the directory. A plan shall

1 *notify the provider 10 days in advance of removal that the provider*
2 *will be removed from the directory.*

3 *(n) This section does not prohibit a plan from requiring its*
4 *risk-bearing organizations or contracting specialized health care*
5 *plans to satisfy the requirements of this section. If a plan delegates*
6 *the responsibility of complying with this section to its risk-bearing*
7 *organizations or contracting specialized health care plans, the*
8 *plan shall ensure that the requirements of this section are met. A*
9 *plan shall retain responsibility for the implementation of this*
10 *section, unless that delegated responsibility has been separately*
11 *negotiated and specifically documented in written contracts*
12 *between the plan and a risk-bearing organization or contracting*
13 *specialized health care plan.*

14 *(o) Every health care service plan shall ensure processes are*
15 *in place to allow providers to promptly verify or submit changes*
16 *to the information required to be in the directory pursuant to this*
17 *section. Those processes shall, at a minimum, include an online*
18 *interface for providers to submit verification or changes*
19 *electronically and shall allow providers to receive an*
20 *acknowledgment of receipt from the health care service plan.*
21 *Providers shall verify or submit changes to information required*
22 *to be in the directory pursuant to this section using the process*
23 *required by the health plan.*

24 *(p) The plan shall establish and maintain a process for enrollees,*
25 *potential enrollees, other providers, and the public to identify and*
26 *report possible inaccurate, incomplete, confusing, or misleading*
27 *information currently listed in the plan's provider directory or*
28 *directories. These processes shall, at a minimum, include a*
29 *telephone number and a dedicated email address at which the plan*
30 *will accept these reports, as well as a hyperlink on the plan's*
31 *provider directory Internet Web page linking to a form where the*
32 *information can be reported directly to the plan through its Internet*
33 *Web site.*

34 *(q) (1) Whenever a health care service plan receives a report*
35 *indicating that information listed in its provider directory or*
36 *directories is inaccurate, incomplete, confusing, or misleading,*
37 *the plan shall immediately investigate the reported inaccuracy*
38 *and, no later than 30 days following receipt of the communication,*
39 *either verify the accuracy of the information or update the*
40 *information in its provider directory or directories, as applicable.*

1 (2) *When investigating a communication regarding its provider*
2 *directory or directories, the plan shall, at a minimum, do the*
3 *following:*

4 (A) *Contact the affected provider no later than five business*
5 *days following receipt of the communication.*

6 (B) *Document the receipt and outcome of each communication.*
7 *The documentation shall include the provider's name, location,*
8 *and a description of the plan's investigation, the outcome of the*
9 *investigation, and any changes or updates made to its provider*
10 *directory or directories.*

11 (C) *If changes to a plan's provider directory or directories are*
12 *required as a result of the plan's investigation, the changes to the*
13 *online provider directory shall be made no later than the next*
14 *scheduled weekly update, or the update immediately following that*
15 *update, or sooner if required by federal law or regulations. For*
16 *printed provider directories, the change shall be made no later*
17 *than the next monthly quarterly update, or the monthly quarterly*
18 *update immediately following that update.*

19 (r) *Notwithstanding Sections 1371 and 1371.35, a plan may*
20 *delay payment or reimbursement to a provider who has not*
21 *responded to the plan's attempts to verify the provider's*
22 *information. The plan may delay payment or reimbursement for*
23 *up to 45 business days in addition to the timeframes for provider*
24 *reimbursement pursuant to Sections 1371 and 1371.35. A plan*
25 *may terminate a contract for a pattern or repeated failure of the*
26 *provider or provider group to alert the plan to a change in the*
27 *information required to be in the directory pursuant to this section.*

28 (s) (1) *In circumstances where the department finds that an*
29 *enrollee reasonably relied upon inaccurate, incomplete, confusing,*
30 *or misleading information contained in a health plan's provider*
31 *directory or directories, the department may require the health*
32 *plan to provide coverage for all covered health care services*
33 *provided to the enrollee and to reimburse the enrollee for any*
34 *amount beyond what the enrollee would have paid, had the services*
35 *been delivered by an in-network provider under the enrollee's*
36 *plan contract. Prior to requiring reimbursement in these*
37 *circumstances, the department must conclude that the services*
38 *received by the enrollee were covered services under the enrollee's*
39 *plan contract. In those circumstances, the fact that the services*
40 *were rendered or delivered by a noncontracting or out-of-plan*

1 *provider shall not be used as a basis to deny reimbursement to the*
2 *enrollee.*

3 *(2) In circumstances where an enrollee in the individual market*
4 *reasonably relied upon inaccurate, incomplete, confusing, or*
5 *misleading information contained in a health plan's provider*
6 *directory or directories, the plan shall inform the enrollee of the*
7 *special enrollment period available under subparagraph (E) of*
8 *paragraph (1) of subdivision (d) of Section 1399.845.*

9 *(3) "Risk-bearing organization" shall have the same meaning*
10 *as defined in subdivision (g) of Section 1375.4.*

11 *(t) This section shall apply to plans with Medi-Cal managed*
12 *care contracts with the State Department of Health Care Services*
13 *pursuant to Chapter 7 (commencing with Section 14000) or*
14 *Chapter 8 (commencing with Section 14200) of the Welfare and*
15 *Institutions Code to the extent consistent with federal law and*
16 *guidance.*

17 *(u) A health plan that contracts with multiple employer welfare*
18 *agreements regulated pursuant to Article 4.7 (commencing with*
19 *Section 742.20) of Chapter 1 of Part 2 of Division 1 of the*
20 *Insurance Code shall meet the requirements of this section.*

21 *(v) Nothing in this section shall be construed to alter a*
22 *provider's obligation to provide health care services to an enrollee*
23 *pursuant to the provider's contract with the plan.*

24 ~~SEC. 2. Section 1367.28 is added to the Health and Safety~~
25 ~~Code, to read:~~

26 ~~1367.28. (a) (1) By March 15, 2016, the department and the~~
27 ~~Department of Insurance shall jointly develop uniform provider~~
28 ~~directory standards consistent with this section. These standards~~
29 ~~shall also require directories to be aggregated and searchable to~~
30 ~~determine the plan with which a physician or other provider is~~
31 ~~contracted.~~

32 ~~(2) The department and the Department of Insurance shall seek~~
33 ~~input from interested parties, including holding at least one public~~
34 ~~meeting. In developing the directory standards, the department~~
35 ~~shall take into consideration any requirements for provider~~
36 ~~directories established by the federal Centers for Medicare and~~
37 ~~Medicaid Services.~~

38 ~~(3) By September 15, 2016, or no later than six months after~~
39 ~~the date that provider directory standards are developed a plan~~

1 shall use the developed standards for each product offered by the
2 plan.

3 ~~(4) The uniform provider directory standards shall require the~~
4 ~~plan's public Internet Web site to allow for provider searches by~~
5 ~~name, practice address, National Provider Identifier number,~~
6 ~~California license, facility or identification number, product, tier,~~
7 ~~provider language, medical group, or independent practice~~
8 ~~association, hospital, or clinic, as appropriate.~~

9 ~~(b) A full service health care service plan and a specialized~~
10 ~~mental health plan shall include all of the following information~~
11 ~~in the online provider directory or directories:~~

12 ~~(1) The provider's name, practice location or locations, and~~
13 ~~contact information.~~

14 ~~(2) Type of practitioner.~~

15 ~~(3) National Provider Identifier number.~~

16 ~~(4) California license number and type of license.~~

17 ~~(5) The area of specialty, including board certification, if any.~~

18 ~~(6) (A) For physicians, the medical group, if any.~~

19 ~~(B) Nurse practitioners, physician assistants, psychologists,~~
20 ~~acupuncturists, optometrists, podiatrists, chiropractors, licensed~~
21 ~~clinical social workers, marriage and family therapists, professional~~
22 ~~clinical counselors, nurse midwives, and dentists to the extent their~~
23 ~~services may be accessed and are covered through the contract~~
24 ~~with the plan. The plan may specify in the online provider directory~~
25 ~~or directories that authorization or referral may be required to~~
26 ~~access some providers.~~

27 ~~(C) For federally qualified health centers or primary care clinics,~~
28 ~~the name of the federally qualified health center or clinic.~~

29 ~~(D) For any provider described in subparagraph (A) or (B) who~~
30 ~~is employed by a federally qualified health center or primary care~~
31 ~~clinic, and to the extent their services may be accessed and are~~
32 ~~covered through the contract with the plan, the name of the~~
33 ~~provider, and the name of the federally qualified health center or~~
34 ~~clinic.~~

35 ~~(E) Pharmacies.~~

36 ~~(F) Skilled nursing facilities.~~

37 ~~(G) Urgent care clinics.~~

38 ~~(7) Hospital affiliation or admitting privileges, if any, for~~
39 ~~physicians and other health professionals contracted with the plan~~

1 ~~whose scope of services for the plan include admitting patients~~
2 ~~and who have admitting privileges at a contracted hospital.~~

3 ~~(8) Non-English language, if any, spoken by a health care~~
4 ~~provider or other medical professional as well as non-English~~
5 ~~language spoken by a skilled medical interpreter, if any, on the~~
6 ~~provider's staff.~~

7 ~~(9) Whether a provider is accepting new patients with the~~
8 ~~product selected by the enrollee or potential enrollee.~~

9 ~~(10) Network tier to which the provider is assigned, if the~~
10 ~~participating provider has been divided into subgroupings~~
11 ~~differentiated by the health plan according to enrollee cost-sharing~~
12 ~~levels. Nothing in this section shall be construed to require the use~~
13 ~~of network tiers other than contract and noncontracting tiers.~~

14 ~~(11) A disclosure that enrollees are entitled to full and equal~~
15 ~~access to covered services, including enrollees with disabilities as~~
16 ~~required under the federal Americans with Disabilities Act of 1990~~
17 ~~and Section 504 of the Rehabilitation Act of 1973.~~

18 ~~(12) A disclosure that enrollees are entitled to language~~
19 ~~interpreter services at no cost to the enrollee, including how to~~
20 ~~obtain interpretation services.~~

21 ~~(13) All other information necessary to conduct a search~~
22 ~~pursuant to subparagraph (A) of paragraph (4) of subdivision (a).~~

23 ~~(e) A vision, dental and other specialized health care service~~
24 ~~plan, except for a specialized mental health plan, shall include all~~
25 ~~of the following information for each of the online provider~~
26 ~~directories used by the plan for its networks:~~

27 ~~(1) The provider's name, practice location or locations, and~~
28 ~~contact information.~~

29 ~~(2) Type of practitioner.~~

30 ~~(3) National Provider Identifier number.~~

31 ~~(4) California license number and type of license.~~

32 ~~(5) The area of specialty, including board certification, if any.~~

33 ~~(6) If participating in a group practice, the name of the group~~
34 ~~practice.~~

35 ~~(7) The names of any allied health care professionals to the~~
36 ~~extent there is a direct contract for those services covered through~~
37 ~~the contract with the plan.~~

38 ~~(8) Non-English language, if any, spoken by a health care~~
39 ~~provider or other medical professional as well as non-English~~

1 ~~language spoken by a skilled medical interpreter, if any, on the~~
2 ~~provider's staff.~~

3 ~~(9) Whether a provider is accepting new patients enrolled in the~~
4 ~~product that the directory applies to.~~

5 ~~(10) A disclosure that enrollees are entitled to full and equal~~
6 ~~access to covered services, including enrollees with disabilities as~~
7 ~~required under the federal Americans with Disabilities Act of 1990~~
8 ~~and Section 504 of the Rehabilitation Act of 1973.~~

9 ~~(11) A disclosure that enrollees are entitled to language~~
10 ~~interpreter services at no cost to the enrollee, including how to~~
11 ~~obtain interpretation services.~~

12 ~~(d) (1) The plan shall provide the online directory or directories~~
13 ~~to the department in a format and manner to be specified by the~~
14 ~~department.~~

15 ~~(2) The plan shall demonstrate no less than quarterly to the~~
16 ~~department that the information provided in the provider directory~~
17 ~~or directories is consistent with the information required under~~
18 ~~Sections 1367.03 and 1367.035, and other provisions of this~~
19 ~~chapter. The plan shall ensure that other information reported to~~
20 ~~the department is consistent with the information provided to~~
21 ~~enrollees, potential enrollees, and the department pursuant to this~~
22 ~~section.~~

23 ~~(3) The plan shall demonstrate to the department that enrollees~~
24 ~~or potential enrollees seeking a provider that is contracted with~~
25 ~~the network for a particular product can identify these providers~~
26 ~~and that the provider is accepting new patients. The plan shall~~
27 ~~ensure that the accuracy of the provider directory meets or exceeds~~
28 ~~95 percent with regard to the participation of providers in the~~
29 ~~network, the extent to which the provider is accepting new patients,~~
30 ~~and if any non-English language is spoken by the provider or other~~
31 ~~medical professionals, as well as non-English language spoken by~~
32 ~~a skilled medical interpreter, if any, on the provider's staff.~~

33 ~~(4) The plan shall contact any provider which is listed in the~~
34 ~~provider directory and which has not submitted a claim within the~~
35 ~~past six months for primary care providers, or twelve months for~~
36 ~~specialty care providers, to determine whether the provider is~~
37 ~~accepting patients or referrals from the plan, if claims are paid by~~
38 ~~the plan. If claims are not paid by the plan, the plan shall contact~~
39 ~~any provider that is listed in the provider directory who has not~~
40 ~~submitted encounter data within the past six months for primary~~

1 care providers, or 12 months without encounter data for a specialty
2 care provider. If the provider does not respond within 30 days, the
3 plan shall remove the provider from the provider directory. A plan
4 is not required to terminate a provider who is removed from the
5 directory according to this paragraph. This requirement does not
6 apply to claims or encounter data from new primary care providers
7 in the first six months, or new specialty care providers in the first
8 12 months, of the contract. This paragraph shall not apply if a
9 provider has affirmatively responded under the requirements of
10 subdivision (h) that the provider information is accurate and the
11 provider is continuing to participate in the network.

12 (e) ~~If a contracting provider, or the representative of a~~
13 ~~contracting provider, informs an enrollee or potential enrollee that~~
14 ~~the provider is not accepting new patients, the contract between~~
15 ~~the plan and the provider shall require the provider to inform the~~
16 ~~plan that the provider is not accepting new patients and direct the~~
17 ~~enrollee or potential enrollee to the plan for additional assistance~~
18 ~~in finding a provider and also to the department to inform it of the~~
19 ~~possible inaccuracy in the provider directory. If an enrollee or~~
20 ~~potential enrollee informs a plan of a possible inaccuracy in the~~
21 ~~provider directory or directories, the plan shall immediately~~
22 ~~investigate and undertake corrective action within 30 business~~
23 ~~days to ensure the accuracy of the directory or directories.~~

24 (f) ~~This section does not prohibit a plan from requiring its~~
25 ~~contracting providers, contracting provider groups, or contracting~~
26 ~~specialized health care plans to satisfy the requirements of this~~
27 ~~section. If a plan delegates the responsibility of complying with~~
28 ~~this section to its contracting providers, contracting provider~~
29 ~~groups, or contracting specialized health care plans, the plan shall~~
30 ~~ensure that the requirements of this section are met.~~

31 (g) ~~Every health care service plan shall ensure processes are in~~
32 ~~place to allow providers to promptly verify or submit changes to~~
33 ~~the information required to be in the directory pursuant to this~~
34 ~~section. Those processes shall, at a minimum, include an online~~
35 ~~interface for providers to submit verification or changes~~
36 ~~electronically and shall allow providers to receive an~~
37 ~~acknowledgment of receipt from the health care service plan.~~
38 ~~Providers shall verify or submit changes to information required~~
39 ~~to be in the directory pursuant to this section using the process~~
40 ~~required by the health plan.~~

~~(h) (1) At least every six months the plan shall notify the contracted provider or provider group of the information on the provider or provider group contained in the directory including a list of each product marketed by the plan for the network. The plan shall include with this notification instructions as to how to access and update the information using the online interface in subdivision (g).~~

~~(2) The plan shall require an affirmative response from the provider or provider group acknowledging that the notification was received and attesting that the information in the provider directory is current and accurate. The provider shall update the information required to be in the directory pursuant to this section, including whether or not the provider or provider group is accepting new patients for each product.~~

~~(3) If the plan does not receive an affirmative response and attestation from the provider within 30 business days, the provider shall be removed from the directory.~~

~~(i) Every health care service plan shall allow enrollees to request the information required by this section through their toll-free telephone number, electronically, or in writing. On request of an enrollee or potential enrollee, the plan shall provide the provider directory in printed form. The information provided in printed form may be limited to the geographic region in which the enrollee or potential enrollee resides or intends to reside.~~

~~(j) Notwithstanding the provisions of Section 1371, a plan may use reasonable compliance methods, such as delaying payment or reimbursement to a provider who has not responded or removal of the provider from other directories only until the plan receives an affirmative response and attestation from the provider. A plan may terminate a contract for a pattern or repeated failure of the provider or provider group to alert the plan to a change in the information required to be in the directory pursuant to this section. A plan may not impose any compliance method pursuant to this subdivision without first providing written notice to the provider.~~

~~(k) This section shall apply to plans with Medi-Cal managed care contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of the Welfare and Institutions Code to the extent consistent with federal law and guidance.~~

~~(l) A health plan that contracts with multiple employer welfare agreements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 of the Insurance Code shall meet the requirements of this section.~~

SEC. 3. Section 10133.15 is added to the Insurance Code, to read:

10133.15. (a) ~~Commencing February 1, 2016, a~~ A health insurer that contracts with providers for alternative rates of payment pursuant to Section 10133 shall ~~make available an online publish and maintain~~ provider directory or directories that ~~provide with~~ information on contracting providers that ~~provide~~ deliver health care services to ~~insureds, the insurer's insureds,~~ insureds, including those that accept new patients pursuant to the requirements of this section ~~and Section 10133.1: patients.~~ A provider directory shall not ~~list or~~ include information on a provider that ~~does not have a current is not currently under~~ contract with the insurer.

(b) An insurer shall provide the online directory or directories for the specific network offered for each product using a consistent method of network and product naming, numbering, or other classification method that ensures the public, insureds, potential insureds, the department, and other state or federal agencies can easily identify which providers participate in which networks for which products. An insurer shall use the same consistent naming, numbering, or classification method in provider contracts and communications to ensure that providers can identify the products and networks that they are legally contracted to provide services in. ~~The naming, numbering, or classification shall be consistent across products in order to permit multiplan directories: the networks and insurer products in which a provider participates. By July 31, 2017, or six months after the date provider directory standards are developed under this section, an insurer shall use the naming, numbering, or classification method developed by the department pursuant to subdivision (k).~~

(c) ~~The (1)~~ An online provider directory or directories shall be available on the insurer's Internet Web site to the public, potential insureds, insureds, and providers ~~through a clearly identifiable link or tab and in a manner that is accessible and searchable without any requirement that a member of the public or potential insureds indicate intent to obtain coverage from the insurer: without any restrictions or limitations.~~ The directory or directories shall be

1 ~~available to the public without requiring~~ *accessible without any*
2 *requirement* that an individual seeking the directory information
3 demonstrate coverage with the insurer, *indicate interest in*
4 *obtaining coverage with the insurer*, provide a member
5 *identification or policy number*, provide any other identifying
6 information, or create or access an account.

7 (2) *The online provider directory or directories shall be*
8 *accessible on the insurer's public Internet Web site through a*
9 *clearly identifiable link or tab and in a manner that is accessible*
10 *and searchable by insureds, potential insureds, the public, and*
11 *providers. The insurer's public Internet Web site shall allow*
12 *provider searches by name, practice address, distance from*
13 *specified address, California license number, National Provider*
14 *Identifier number, admitting privileges to an identified hospital,*
15 *product, tier, provider language, medical group or independent*
16 *practice association, hospital name, facility name, or clinic name,*
17 *as appropriate.*

18 (d) (1) *A health insurer shall allow insureds, potential insureds,*
19 *and members of the public to request a printed copy of the provider*
20 *directory or directories by contacting the insurer through the*
21 *insurer's toll-free telephone number, electronically, or in writing.*
22 *A printed copy of the provider directory or directories shall include*
23 *the information required in subdivisions (h) and (i). The printed*
24 *copy of the provider directory or directories shall be provided to*
25 *the insured by mail no later than 15 business days following the*
26 *date of the request and may be limited to the geographic region*
27 *in which the insured resides or works or intends to reside or work.*

28 (2) *A health insurer shall update its printed provider directory*
29 *or directories at least quarterly, or more frequently, if required*
30 *by federal law.*

31 ~~(d)~~

32 (e) *The insurer shall update the online provider directory or*
33 *directories, at least weekly, with any change to contracting*
34 *providers, including all of the following: weekly, or more*
35 *frequently, if required by federal law. Any change in information*
36 *concerning a listed contracting provider shall be included in the*
37 *updated version required by this subdivision. A change in*
38 *information includes, but is not limited to, any of the following:*

39 (1) *Whether a contracting provider is no longer accepting new*
40 *patients for that product, or whether the contracting provider group*

1 has identified that a provider of the group is no longer accepting
2 new patients.

3 ~~(2) Whether the provider moved or relocated from~~ *relocated*
4 *out of* the contracted service area of the insurer, or has retired or
5 has otherwise ceased to practice, ~~in which case~~ *practice. In all of*
6 *these cases*, the provider shall be deleted from the directory.

7 ~~(3) Whether the provider is no longer contracted with the insurer~~
8 ~~for any reason, in which case the provider shall be deleted from~~
9 ~~the directory.~~

10 ~~(4) Whether the contracted provider is no longer under contract~~
11 ~~for a particular product.~~

12 ~~(5) Whether the provider's practice location or other~~
13 ~~information required under subdivision (h) has changed.~~

14 ~~(3)~~

15 ~~(6) Whether the contracting provider group, medical group,~~
16 ~~independent practice association, or other group of providers, if~~
17 ~~any, has informed the insurer that the provider is no longer~~
18 ~~associated with the group and is no longer under contract with the~~
19 ~~plan, insurer, in which case the provider shall be deleted from the~~
20 ~~directory.~~

21 ~~(7) Whether the contracting medical group, independent practice~~
22 ~~association, or other group of providers has informed the insurer~~
23 ~~that the provider group is no longer under contract with the~~
24 ~~insurer, in which case any provider of the group that does not~~
25 ~~maintain an independent contract with the insurer shall be deleted~~
26 ~~from the directory.~~

27 ~~(4)~~

28 ~~(8) When the plan insurer identified a change is necessary based~~
29 ~~on an insured complaint that a provider was not accepting new~~
30 ~~patients, was otherwise not available, or whose contact information~~
31 ~~was listed incorrectly.~~

32 ~~(5)~~

33 ~~(9) Any other relevant information that has come to the attention~~
34 ~~of the product affecting the content and accuracy of the provider~~
35 ~~directory.~~

36 ~~(e)~~

37 ~~(f) The online provider directory or directories shall include~~
38 ~~both an email address and a telephone number for members of the~~
39 ~~public and providers to notify the insurer if the provider directory~~
40 ~~information appears to be inaccurate.~~

1 ~~(f)~~

2 (g) The ~~online~~ provider directory shall include the following
3 disclosures informing insureds that they are entitled to both of the
4 following:

5 (1) Language interpreter services, at no cost to the insured,
6 including how to obtain interpretation services.

7 (2) Full and equal access to covered services, including insureds
8 with disabilities as required under the federal Americans with
9 Disabilities Act of 1990 and Section 504 of the Rehabilitation Act
10 of 1973.

11 (h) *The health insurer and a specialized mental health insurer*
12 *shall include all of the following information in the provider*
13 *directory or directories:*

14 (1) *The provider's name, practice location or locations, and*
15 *contact information.*

16 (2) *Type of practitioner.*

17 (3) *National Provider Identifier number.*

18 (4) *California license number and type of license.*

19 (5) *The area of specialty, including board certification, if any.*

20 (6) *The provider's office email address, if available.*

21 (7) *The name of all affiliated medical groups currently under*
22 *contract with the insurer through which the provider sees enrollees.*

23 (8) *A listing for each of the following providers, facilities, and*
24 *services that are under contract with the insurer:*

25 (A) *For physicians and surgeons, the medical group, and*
26 *affiliation or admitting privileges, if any, at hospitals contracted*
27 *with the insurer.*

28 (B) *Nurse practitioners, physician assistants, psychologists,*
29 *acupuncturists, optometrists, podiatrists, chiropractors, licensed*
30 *clinical social workers, marriage and family therapists,*
31 *professional clinical counselors, substance abuse counselors,*
32 *qualified autism service providers, nurse midwives, and dentists.*

33 (C) *For federally qualified health centers or primary care*
34 *clinics, the name of the federally qualified health center or clinic.*

35 (D) *For any provider described in subparagraph (A) or (B) who*
36 *is employed by a federally qualified health center or primary care*
37 *clinic, and to the extent their services may be accessed and are*
38 *covered through the contract with the insurer, the name of the*
39 *provider, and the name of the federally qualified health center or*
40 *clinic.*

1 (E) Facilities, including but not limited to, general acute care
2 hospitals, skilled nursing facilities, urgent care clinics, ambulatory
3 surgery centers, inpatient hospice, residential care facilities, and
4 inpatient rehabilitation facilities.

5 (F) Pharmacies, clinical laboratories, imaging centers, and
6 other facilities providing contracted health care services.

7 (9) The provider directory may note that authorization or
8 referral may be required to access some providers.

9 (10) Non-English language, if any, spoken by a health care
10 provider or other medical professional as well as non-English
11 language spoken by a qualified medical interpreter, in accordance
12 with Section 1367.04 of the Health and Safety Code, if any, on the
13 provider's staff.

14 (11) Identification of providers who no longer accept new
15 patients for one or more of the insurer's products or for all of the
16 insurer's products.

17 (12) Network tier to which the provider is assigned, if the
18 provider is not in the lowest tier, as applicable. Nothing in this
19 section shall be construed to require the use of network tiers other
20 than contract and noncontracting tiers.

21 (13) All other information necessary to conduct a search
22 pursuant to paragraph (2) of subdivision (c).

23 (i) A vision, dental, or other specialized insurer, except for a
24 specialized mental health insurer, shall include all of the following
25 information for each of the provider directories used by the insurer
26 for its networks:

27 (1) The provider's name, practice location or locations, and
28 contact information.

29 (2) Type of practitioner.

30 (3) National Provider Identifier number.

31 (4) California license number and type of license, if applicable.

32 (5) The area of specialty, including board certification, or other
33 accreditation, if any.

34 (6) The provider's office email address, if available.

35 (7) The name of any affiliated medical group, independent
36 practice association, or specialty insurer practice group currently
37 under contract with the insurer through which the provider sees
38 insureds.

1 (8) *The names of any allied health care professionals to the*
2 *extent there is a direct contract for those services covered through*
3 *the contract with the insurer.*

4 (9) *Non-English language, if any, spoken by a health care*
5 *provider or other medical professional as well as non-English*
6 *language spoken by a qualified medical interpreter, in accordance*
7 *with Section 1367.04 of the Health and Safety Code, if any, on the*
8 *provider's staff.*

9 (j) *If a contracting provider, or the representative of a*
10 *contracting provider, informs an insured or potential insured who*
11 *contacted the provider based on information in the provider*
12 *directory indicating that the provider was accepting new patients*
13 *but the provider is not accepting new patients, then the contract*
14 *between the insurer and the provider shall require the provider to*
15 *inform the insurer that the provider is not accepting new patients*
16 *and direct the insured or potential insured to the insurer for*
17 *additional assistance in finding a provider and also to the*
18 *department to inform it of the possible inaccuracy in the provider*
19 *directory. If an insured or potential insured informs an insurer of*
20 *a possible inaccuracy in the provider directory or directories, the*
21 *insurer shall immediately investigate and, if necessary, undertake*
22 *corrective action within 30 business days to ensure the accuracy*
23 *of the directory or directories.*

24 (k) (1) *On or before December 31, 2016, the department shall*
25 *develop uniform provider directory standards for purposes of this*
26 *section. Those standards shall not be subject to the Administrative*
27 *Procedure Act (Chapter 3.5 (commencing with Section 11340) of*
28 *Part 1 of Division 3 of Title 2 of the Government Code), until*
29 *January 1, 2021.*

30 (2) *In developing the standards under this subdivision, the*
31 *department shall seek input from interested parties and shall hold*
32 *at least one public meeting. The department shall take into*
33 *consideration any requirements for provider directories established*
34 *by the federal Centers for Medicare and Medicaid Services.*

35 (3) *By July 31, 2017, or six months after the date provider*
36 *directory standards are developed under this subdivision,*
37 *whichever occurs later, an insurer shall use the standards*
38 *developed by the department for each product offered by the*
39 *insurer.*

1 *(l) An insurer shall establish policies and procedures with*
2 *regard to the regular updating of its provider directory or*
3 *directories, including the weekly, quarterly, and annual updates*
4 *required pursuant to this section, or more frequently, if required*
5 *by federal law or guidance.*

6 *(m) The policies and procedures established under this*
7 *subdivision shall be submitted by an insurer annually to the*
8 *department for approval and in a format described by the*
9 *department.*

10 *(1) At a minimum, these policies and procedures shall include*
11 *all of the following:*

12 *(A) At least annually, the insurer shall review and update the*
13 *entire provider directory or directories for each product offered.*

14 *(B) At least quarterly, the insurer shall notify the contracted*
15 *provider or provider group, if applicable, of the information the*
16 *insurer has in the directory or directories on the provider or*
17 *provider group contained in the directory, including a list of*
18 *networks and insurer products that include the contracted provider*
19 *or provider group. The insurer shall include with this notification*
20 *instructions as to how the provider or provider group can access*
21 *and update the information using the online interface required by*
22 *subdivision (o).*

23 *(2) The insurer shall require an affirmative response from the*
24 *provider or provider group acknowledging that the notification*
25 *was received. The provider or provider group shall attest that the*
26 *information in the provider directory is current and accurate or*
27 *update the information required to be in the directory pursuant to*
28 *this section, including whether or not the provider or provider*
29 *group is accepting new patients for each insurer product.*

30 *(3) If the insurer does not receive an affirmative response and*
31 *attestation from the provider that the information is current and*
32 *accurate or, as an alternative, updates information required to be*
33 *in the directory pursuant to this section, within 30 business days,*
34 *the insurer shall take investigatory actions as outlined in*
35 *subdivision (q) to verify whether the provider's information is*
36 *correct or requires updates. The insurer shall complete its*
37 *investigation and make any required corrections or updates to the*
38 *provider directory based on its investigation within 30 days from*
39 *the date the provider was required to provide the affirmative*
40 *response to the insurer. If, at the completion of its investigation,*

1 *the insurer is unable to verify whether the provider's information*
2 *is correct or requires updates, the provider shall be removed from*
3 *the directory. An insurer shall notify the provider 10 days in*
4 *advance of removal that the provider will be removed from the*
5 *directory.*

6 *(n) This section does not prohibit an insurer from requiring its*
7 *risk-bearing organizations or contracting specialized health*
8 *insurers to satisfy the requirements of this section. If an insurer*
9 *delegates the responsibility of complying with this section to its*
10 *risk-bearing organizations or contracting specialized health*
11 *insurers, the insurer shall ensure that the requirements of this*
12 *section are met. An insurer shall retain responsibility for the*
13 *implementation of this section, unless that delegated responsibility*
14 *has been separately negotiated and specifically documented in*
15 *written contracts between the insurer and a risk-bearing*
16 *organization or contracting specialized health insurer.*

17 *(o) Every health insurer shall ensure processes are in place to*
18 *allow providers to promptly verify or submit changes to the*
19 *information required to be in the directory pursuant to this section.*
20 *Those processes shall, at a minimum, include an online interface*
21 *for providers to submit verification or changes electronically and*
22 *shall allow providers to receive an acknowledgment of receipt*
23 *from the health insurer. Providers shall verify or submit changes*
24 *to information required to be in the directory pursuant to this*
25 *section using the process required by the health insurer.*

26 *(p) The insurer shall establish and maintain a process for*
27 *insureds, potential insureds, other providers, and the public to*
28 *identify and report possible inaccurate, incomplete, confusing, or*
29 *misleading information currently listed in the insurer's provider*
30 *directory or directories. These processes shall, at a minimum,*
31 *include a telephone number and a dedicated email address at*
32 *which the insurer will accept these reports, as well as a hyperlink*
33 *on the insurer's provider directory Internet Web page linking to*
34 *a form where the information can be reported directly to the*
35 *insurer through its Internet Web site.*

36 *(q) (1) Whenever a health insurer receives a report indicating*
37 *that information listed in its provider directory or directories is*
38 *inaccurate, incomplete, confusing, or misleading, the insurer shall*
39 *immediately investigate the reported inaccuracy and, no later than*
40 *30 days following receipt of the communication, either verify the*

1 accuracy of the information or update the information in its
2 provider directory or directories, as applicable.

3 (2) When investigating a communication regarding its provider
4 directory or directories, the insurer shall, at a minimum, do the
5 following:

6 (A) Contact the affected provider no later than five business
7 days following receipt of the communication.

8 (B) Document the receipt and outcome of each communication.
9 The documentation shall include the provider's name, location,
10 and a description of the insurer's investigation, the outcome of
11 the investigation, and any changes or updates made to its provider
12 directory or directories.

13 (C) If changes to an insurer's provider directory or directories
14 are required as a result of the insurer's investigation, the changes
15 to the online provider directory shall be made no later than the
16 next scheduled weekly update, or the update immediately following
17 that update, or sooner if required by federal law or regulations.
18 For printed provider directories, the change shall be made no
19 later than the next monthly quarterly update, or the monthly
20 quarterly update immediately following that update.

21 (r) Notwithstanding Section 10123.13, an insurer may delay
22 payment or reimbursement to a provider who has not responded
23 to the insurer's attempts to verify the provider's information. The
24 insurer may delay payment or reimbursement for up to 45 business
25 days in addition to the timeframes for provider reimbursement
26 pursuant to Section 10123.13. An insurer may terminate a contract
27 for a pattern or repeated failure of the provider or provider group
28 to alert the insurer to a change in the information required to be
29 in the directory pursuant to this section.

30 (s) (1) In circumstances where the department finds that an
31 insured reasonably relied upon inaccurate, incomplete, confusing,
32 or misleading information contained in an insurer's provider
33 directory or directories, the department may require the insurer
34 to provide coverage for all covered health care services provided
35 to the insured and to reimburse the insured for any amount beyond
36 what the insured would have paid, had the services been delivered
37 by an in-network provider under the insured's insurance contract.
38 Prior to requiring reimbursement in these circumstances, the
39 department must conclude that the services received by the insured
40 were covered services under the insured's insurance contract. In

1 *those circumstances, the fact that the services were rendered or*
2 *delivered by a noncontracting or out-of-network provider shall*
3 *not be used as a basis to deny reimbursement to the insured.*

4 (2) *In circumstances where an insured in the individual market*
5 *reasonably relied upon inaccurate, incomplete, confusing, or*
6 *misleading information contained in an insurer's provider*
7 *directory or directories, the insurer shall inform the insured of the*
8 *special enrollment period available under subparagraph (E) of*
9 *paragraph (1) of subdivision (d) of Section 10965.3.*

10 (3) *"Risk-bearing organization" shall have the same meaning*
11 *as defined in subdivision (g) of Section 1375.4 of the Health and*
12 *Safety Code.*

13 (t) *An insurer that contracts with multiple employer welfare*
14 *agreements regulated pursuant to Article 4.7 (commencing with*
15 *Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet*
16 *the requirements of this section.*

17 (u) *Nothing in this section shall be construed to alter a*
18 *provider's obligation to provide health care services to an insured*
19 *pursuant to the provider's contract with the insurer.*

20 ~~SEC. 4. Section 10133.16 is added to the Insurance Code, to~~
21 ~~read:~~

22 ~~10133.16. (a) (1) By March 15, 2016, the department and the~~
23 ~~Department of Managed Health Care shall jointly develop uniform~~
24 ~~provider directory standards consistent with this section. These~~
25 ~~standards shall also require directories to be aggregated and~~
26 ~~searchable to determine the insurer with which a physician or other~~
27 ~~provider is contracted.~~

28 ~~(2) The department and the Department of Managed Health~~
29 ~~Care shall seek input from interested parties, including holding at~~
30 ~~least one public meeting. In developing the directory standards,~~
31 ~~the department shall take into consideration any requirements for~~
32 ~~provider directories established by the federal Centers for Medicare~~
33 ~~and Medicaid Services.~~

34 ~~(3) By September 15, 2016, or no later than six months after~~
35 ~~the date that provider directory standards are developed, an insurer~~
36 ~~shall use the developed standards for each product offered by the~~
37 ~~insurer.~~

38 ~~(4) The uniform provider directory standards shall require the~~
39 ~~insurer's public Internet Web site to allow for provider searches~~
40 ~~by name, practice address, National Provider Identifier number,~~

1 ~~California license number, facility or identification number,~~
2 ~~product, tier, provider language, medical group, or independent~~
3 ~~practice association, hospital, or clinic, as appropriate.~~

4 ~~(b) The insurer and a specialized mental health insurer shall~~
5 ~~include all of the following information in the online provider~~
6 ~~directory or directories:~~

7 ~~(1) The provider's name, practice location or locations, and~~
8 ~~contact information.~~

9 ~~(2) Type of practitioner.~~

10 ~~(3) National Provider Identifier number.~~

11 ~~(4) California license number and type of license.~~

12 ~~(5) The area of specialty, including board certification, if any.~~

13 ~~(6) (A) For physicians, the medical group, if any.~~

14 ~~(B) Nurse practitioners, physician assistants, psychologists,~~
15 ~~acupuncturists, optometrists, podiatrists, chiropractors, licensed~~
16 ~~clinical social workers, marriage and family therapists, professional~~
17 ~~clinical counselors, nurse midwives, and dentists to the extent their~~
18 ~~services may be accessed and are covered through the contract~~
19 ~~with the insurer. The insurer may specify in the provider directory~~
20 ~~or directories that authorization or referral may be required to~~
21 ~~access some providers.~~

22 ~~(C) For federally qualified health centers or primary care clinics,~~
23 ~~the name of the federally qualified health center or clinic.~~

24 ~~(D) For any provider described in subparagraph (A) or (B) who~~
25 ~~is employed by a federally qualified health center or primary care~~
26 ~~clinic, and to the extent their services may be accessed and are~~
27 ~~covered through the contract with the insurer, the name of the~~
28 ~~provider, and the name of the federally qualified health center or~~
29 ~~clinic.~~

30 ~~(E) Pharmacies.~~

31 ~~(F) Skilled nursing facilities.~~

32 ~~(G) Urgent care clinics.~~

33 ~~(7) Hospital affiliation or admitting privileges, if any, for~~
34 ~~physicians and other health professionals contracted with the~~
35 ~~insurer whose scope of services for the product include admitting~~
36 ~~patients and who have admitting privileges at a contracted hospital.~~

37 ~~(8) Non-English language, if any, spoken by a health care~~
38 ~~provider or other medical professional as well as non-English~~
39 ~~language spoken by a skilled medical interpreter, if any, on the~~
40 ~~provider's staff.~~

~~(9) Whether a provider is accepting new patients with the product selected by the insured or potential insured.~~

~~(10) Network tier that the provider is assigned if the participating provider has been divided into subgroupings differentiated by the insurer according to insured cost-sharing levels or quality scores. Nothing in this section shall be construed to require the use of network tiers other than contract and noncontracting tiers.~~

~~(11) A disclosure that insureds are entitled to full and equal access to covered services, including insureds with disabilities as required under the federal Americans with Disabilities Act of 1990 and Section 504 of the Rehabilitation Act of 1973.~~

~~(12) A disclosure that insureds are entitled to language interpreter services at no cost to the insured, including how to obtain interpretation services.~~

~~(13) All other information necessary to conduct a search pursuant to subparagraph (A) of paragraph (4) of subdivision (a).~~

~~(e) A vision, dental, and other specialized insurer, except for a specialized mental health insurer, shall include all of the following information for each of the online provider directories used by the insurer for its networks:~~

~~(1) The provider's name, practice location or locations, and contact information.~~

~~(2) Type of practitioner.~~

~~(3) National Provider Identifier number.~~

~~(4) California license number and type of license.~~

~~(5) The area of specialty, including board certification, if any.~~

~~(6) If participating in a group practice, the name of the group practice.~~

~~(7) The names of any allied health care professionals to the extent there is a direct contract for those services covered through the contract with the insurer.~~

~~(8) Non-English language, if any, spoken by a health care provider or other medical professional as well as non-English language spoken by a skilled medical interpreter, if any, on the provider's staff.~~

~~(9) Whether a provider is accepting new patients enrolled in the product that the directory applies to.~~

~~(10) A disclosure that insureds are entitled to full and equal access to covered services, including insureds with disabilities as~~

1 required under the federal Americans with Disabilities Act of 1990
2 and Section 504 of the Rehabilitation Act of 1973.

3 ~~(11) A disclosure that insureds are entitled to language~~
4 ~~interpreter services at no cost to the insured, including how to~~
5 ~~obtain interpretation services.~~

6 ~~(d) (1) The insurer shall provide the online directory or~~
7 ~~directories to the department in a format and manner to be specified~~
8 ~~by the department.~~

9 ~~(2) The insurer shall demonstrate no less than quarterly to the~~
10 ~~department that the information provided in the provider directory~~
11 ~~or directories is consistent with the information required under~~
12 ~~Section 10133.5 and other provisions of this part. The insurer shall~~
13 ~~ensure that other information reported to the department is~~
14 ~~consistent with the information provided to insureds, potential~~
15 ~~insureds, and the department pursuant to this section.~~

16 ~~(3) The insurer shall demonstrate to the department that insureds~~
17 ~~or potential insureds seeking a provider that is contracted with the~~
18 ~~network for a particular product can identify these providers and~~
19 ~~that the provider is accepting new patients. The insurer shall ensure~~
20 ~~that the accuracy of the provider directory meets or exceeds 95~~
21 ~~percent with regard to the participation of providers in the network,~~
22 ~~the extent to which the provider is accepting new patients, as well~~
23 ~~as non-English language spoken by a skilled medical interpreter,~~
24 ~~if any, on the provider's staff.~~

25 ~~(4) The insurer shall contact any provider which is listed in the~~
26 ~~provider directory and which has not submitted a claim within the~~
27 ~~past six months for primary care providers, or 12 months for~~
28 ~~specialty care providers, to determine whether the provider is~~
29 ~~accepting patients or referrals from the insurer, if claims are paid~~
30 ~~by the insurer. If the provider does not respond within 30 days,~~
31 ~~the insurer shall remove the provider from the provider directory.~~
32 ~~An insurer is not required to terminate a provider who is removed~~
33 ~~from the directory according to this paragraph. This requirement~~
34 ~~does not apply to claims or claim data from new primary care~~
35 ~~providers in the first six months, or new specialty care providers~~
36 ~~in the first 12 months, of the contract. This paragraph shall not~~
37 ~~apply if a provider has affirmatively responded under the~~
38 ~~requirements of subdivision (h) that the provider information is~~
39 ~~accurate and the provider is continuing to participate in the~~
40 ~~network.~~

~~(e) If a contracting provider, or the representative of a contracting provider, informs an insured or potential insured that the provider is not accepting new patients, the contract between the insurer and the provider shall require the provider to inform the insurer that the provider is not accepting new patients and direct the insured or potential insured to the insurer for additional assistance in finding a provider and also to the department to inform it of the possible inaccuracy in the provider directory. If an insured or potential insured informs an insurer of a possible inaccuracy in the provider directory or directories, the insurer shall immediately investigate and undertake corrective action within 30 business days to ensure the accuracy of the directory or directories.~~

~~(f) This section does not prohibit an insurer from requiring its contracting providers, contracting provider groups, or contracting specialized health care plans to satisfy the requirements of this section. If an insurer delegates the responsibility of complying with this section to its contracting providers, contracting provider groups, or contracting specialized health care plans, the insurer shall ensure that the requirements of this section are met.~~

~~(g) Every insurer shall ensure processes are in place to allow providers to promptly verify or submit changes to the information required to be in the directory pursuant to this section. Those processes shall, at a minimum, include an online interface for providers to submit verification or changes electronically and shall allow providers to receive an acknowledgment of receipt from the health insurer. Providers shall verify or submit changes to information required to be in the directory pursuant to this section using the process required by the insurer.~~

~~(h) (1) At least once every six months the insurer shall notify the contracted provider or provider group of the information on the provider or provider group contained in the directory including a list of each product marketed by the insurer for the network. The insurer shall include with this notification, instructions as to how to access and update the information using the online interface in subdivision (g).~~

~~(2) The insurer shall require an affirmative response from the provider or provider group acknowledging that the notification was received and attesting that the information in the provider directory is current and accurate. The provider shall update the information required to be in the directory pursuant to this section,~~

1 including whether or not the provider or provider group is accepting
2 new patients for each product.

3 ~~(3) If the insurer does not receive an affirmative response and~~
4 ~~attestation from the provider within 30 business days, the provider~~
5 ~~shall be removed from the directory.~~

6 ~~(i) Every health insurer shall allow insureds to request the~~
7 ~~information required by this section through their toll-free~~
8 ~~telephone number, electronically, or in writing. On request of an~~
9 ~~insured or potential insured, the insurer shall provide the provider~~
10 ~~directory in printed form. The information provided in printed~~
11 ~~form may be limited to the geographic region in which the insured~~
12 ~~or potential insured resides or intends to reside.~~

13 ~~(j) Notwithstanding the provisions of Section 10123.13, an~~
14 ~~insurer may use reasonable compliance methods, such as delaying~~
15 ~~payment or reimbursement to a provider who has not responded~~
16 ~~or removal of the provider from other directories only until the~~
17 ~~plan receives an affirmative response and attestation from the~~
18 ~~provider. An insurer may terminate a contract for a pattern or~~
19 ~~repeated failure of the provider or provider group to alert the insurer~~
20 ~~to a change in the information required to be in the directory~~
21 ~~pursuant to this section. An insurer may not impose any compliance~~
22 ~~method pursuant to this subdivision without first providing written~~
23 ~~notice to the provider.~~

24 ~~(k) An insurer that contracts with multiple employer welfare~~
25 ~~agreements regulated pursuant to Article 4.7 (commencing with~~
26 ~~Section 742.20) of Chapter 1 of Part 2 of Division 1 shall meet the~~
27 ~~requirements of this section.~~

28 ~~SEC. 5.~~

29 *SEC. 4.* No reimbursement is required by this act pursuant to
30 Section 6 of Article XIII B of the California Constitution because
31 the only costs that may be incurred by a local agency or school
32 district will be incurred because this act creates a new crime or
33 infraction, eliminates a crime or infraction, or changes the penalty
34 for a crime or infraction, within the meaning of Section 17556 of
35 the Government Code, or changes the definition of a crime within
36 the meaning of Section 6 of Article XIII B of the California
37 Constitution.